

BLIND *and*  
PARTIALLY SEEING  
CHILDREN *in* ILLINOIS



ILLINOIS COMMISSION *for*  
HANDICAPPED CHILDREN

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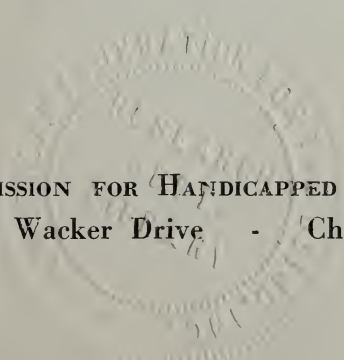
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BLIND  
*and*  
PARTIALLY SEEING  
CHILDREN  
*in*  
ILLINOIS

SOME FACTS CONCERNING THEM  
AND A SUGGESTED PROGRAM  
FOR THEIR CARE

ILLINOIS COMMISSION FOR HANDICAPPED CHILDREN  
211 West Wacker Drive - Chicago



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## FOREWORD

The purpose of the Illinois Commission for Handicapped Children in presenting this study is the promotion of more adequate services throughout the State for those children who have or are threatened with defective vision.

This publication is an attempt to define the numerous problems confronted by the blind or partially seeing child, his family, and his community; to indicate some means of helping to solve those problems; and to suggest possible ways of putting those means to work here in Illinois. It is not a technical study designed to add to the knowledge of specialists in the field. It is rather a statement of general principles which should be considered in the development of a sound overall program.

The ideas set forth here are the synthesis of the thinking of many persons and groups, to all of whom we are grateful for the helpful suggestions they have made.

Special acknowledgment is due the Committee, Dr. Harry S. Gradle, Mrs. Audrey Hayden Gradle, Miss Evelyn Horton, Miss Miriam Norris, Mr. Raymond Dickinson, and Mr. Robert W. Woolston, who gave generously of their time in reading the manuscript and in consultation with the staff on its contents. Acknowledgement is also due Miss Elizabeth Mills, Medical Social Service Consultant of the University of Illinois Division of Services for Crippled Children, for her work in compiling the material of the manuscript, and Mrs. Virginia Bonnici, Librarian, and Miss Jane Bull, Acting Director of this Commission, for their respective contributions in gathering the preliminary material and editing the manuscript.

Mrs. Harry M. Mulberry,

November 1945

Chairman



# *Blind and Partially Seeing Children In Illinois*

## *Nature and Significance of Defective Vision*

Blindness is a term which covers a fairly wide range of visual defects, and refers to severe limitation either in the sharpness of sight or in the size of the area which can be seen at one time. A blind person may be totally unable to distinguish light from dark, or he may be able to distinguish large objects without being able to read even the largest print, or he may see only in a tiny circle straight ahead of him. In any of these conditions he would not have enough sight to serve him for the ordinary activities of life for which sight is essential.

Workers with the blind are in general agreement on the following standard definition of blindness: "Visual acuity of 20/200 or less in the better eye with correcting lenses, or a limitation in the field of vision so great as to constitute a handicap equivalent to the foregoing."<sup>1</sup> 20/200 visual acuity constitutes about 80 per cent loss of vision; it means that the individual 20 feet away from the standard Snellen test chart can read only what a normally sighted person could read 200 feet away from the chart. The field of vision is the space within which an object can be seen while the eye remains fixed upon some one point. If the field is cut down on the outer side of the eye, one cannot distinguish objects approaching from that side, a defect which, even in small degree, is dangerous in such activities as driving a car or crossing a busy

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<sup>1</sup> Robert B. Irwin, "The Blind and Resources for Their Aid," in *What of the Blind?*, Helga Lende, comp., p. 3.

street. Determining limits in the visual field is a highly technical process, but can be done with exactness by trained persons.

Some individual cases do not fit exactly into this standard definition of blindness, because of differences between sharpness of vision for close work and at a distance or because of other variations, but such cases do not invalidate the general usefulness of the definition.

Partial sight is defined less precisely than blindness. In general, the person with vision between 20/70 and 20/200 in the better eye with correcting lenses is classed as partially seeing. This is a range of from 36 to 80 per cent loss of vision. Limits in the field of vision would be similarly classified; in other words, the person who does not have full field of vision and is handicapped thereby, though he is still able to function as a sighted person, is considered partially sighted. There are some persons with progressive eye difficulties or diseases of the eye who must be considered visually handicapped even though they may test above 20/70 on the standard chart. In a number of common eye difficulties, such as near- and far-sightedness, vision may be very low without glasses, and until the proper glasses are worn the individual is definitely handicapped.<sup>2</sup>

**Significance of Visual Handicap.** Society has long recognized that blindness is of major significance to the individual, but there has not always been recognition of the precise handicaps it may entail. Some of these are real and inevitable, others only potential, or capable of being avoided or greatly lessened through proper training and services. They will also

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<sup>2</sup> See Winifred Hathaway, *Education and Health of the Partially Seeing Child*, (New York: Columbia University Press, 1943) Ch. II and Appendix 2.

vary according to individual differences in physical and mental status, the age at which sight was lost, personality, social adjustment, past experience, and in the attitudes of the individual's family toward the blindness.

The blind child lacks an extremely important group of learning experiences, those which depend on sight. He therefore has a narrower range of stimuli than the seeing child has. His education requires the substitution of sound and touch for sight, and even where this is most successfully done, it means slower and more difficult learning than for the sighted child.

The reactions of most persons to the blind child are somewhat different from their reactions to the seeing child. Some may express their sympathy for his handicap unwisely through overprotection, which carries great danger for him. Others, made uncomfortable by his difference, and not recognizing his individual personality as apart from his physical defect, may either isolate or actively reject him. Any of these reactions, particularly when they come from members of his own family, put him at great disadvantage in developing a wholesome personality and in learning to live happily in a world of sighted people.

Blindness is costly, in money and in other values, to the individual and to society. Any blind person from time to time requires some service from sighted people, and if this is not available from family or friends, it must be purchased. Reader and guide service are examples. In addition, there are many other ways in which the cost of living may be higher for the blind, as in higher cleaning and laundry bills, greater use of the telephone, and need to use the more expensive forms of transportation. The fact that the

average earnings of the blind are substantially less than those of the sighted serves to intensify their economic problem.

Although the organized special services needed by the blind are expensive, they are less costly than permitting the blind to become completely dependent and helpless. In the country as a whole many millions of dollars are spent in such programs every year. Of even greater significance is the fact that the poorly adjusted or inadequately trained blind person will not be able to make his full contribution to the society in which he lives. To the extent that this occurs, society suffers, since a democracy functions best as the greatest possible number of its citizens participate fully in its activities.

In so far as the partially seeing person by reason of his visual defect has limitations on his experiences and his social participation, he too is handicapped and society loses. He has the problem of living as a sighted person, though with limitations, rather than as one who cannot use sight in his daily activities. Partially seeing children may be bothered by a sense of difference, and by not always being able to share the activities of sighted children. Their vocational handicap may be quite severe, though there are many more jobs the partially sighted person can do than he cannot do. His problem requires special and often expensive attention; his disadvantage, though real, is not as severe as that of the blind.

**Principal Causes of Blindness.** Although accurate and extensive data on causes of blindness are lacking, the subject has received a good deal of expert attention, and some useful figures have been gathered. The American Foundation for the Blind and the National Society for the Prevention of Blindness have



sponsored jointly for some years a Committee on Statistics of the Blind, which has gathered data and worked out a standard classification of causes of blindness.

A 1943 report prepared by this Committee<sup>3</sup> on causes of blindness of students in schools and day classes for the blind in the United States shows that the principal causes among children are divided as follows:

|                                          |       |
|------------------------------------------|-------|
| Prenatal origin .....                    | 52.4% |
| Infectious diseases .....                | 24.0% |
| Cause undetermined or not specified..... | 11.6% |
| Injuries .....                           | 7.7%  |
| Tumors, etc. ....                        | 2.8%  |
| General diseases .....                   | 1.4%  |
| Poisoning .....                          | 0.1%  |

Studies of students in schools for the blind over a period of years show that there has been a definite shift in distribution of these causes. The most significant item in the shift is the decrease in cases of blindness due to infectious diseases. This is principally because of improved programs for the prevention of gonorrheal ophthalmia of the new born (babies' sore eyes) and for the treatment of syphilis. Public health measures which have prevented or successfully treated cases of measles, scarlet fever, smallpox, and meningitis, have also prevented blindness.

We do not have figures which show the effect of safety education and accident prevention, although both have received increasing attention in recent years. As infectious diseases and accident become relatively less important causes of blindness, condi-

<sup>3</sup> C. Edith Kerby, "Eye Conditions Among Pupils in Schools for the Blind in the United States 1941-42," *Outlook for the Blind*, XXXVII, November, 1943, pp. 245-252.

tions of prenatal origin take a larger place in the whole.

**Association with other Defects.** Visual defect may, of course, be associated with any other type of physical or mental abnormality. Certain injuries or disease which cause damage to the eye may also affect other body structures, or visual defect and other nerve or motor disorder may develop independently. The child with more than one defect is likely to be more severely handicapped than the child with only one, and there is some danger that while attention and special services are given for one handicap, the other may be overlooked. In general, major emphasis should be placed on that defect which presents the more severe problem in the child's adjustment, but no program can be considered adequate which does not evaluate, plan, and act in relation to all defects.

Perhaps the best-known association of visual with other defects is in the deaf-blind, although the number of persons with this double handicap is fortunately very small. The deaf-blind child is one of the most severely handicapped we know, and requires great care and specialized services if he is to have opportunity for development.

Visual defects are not infrequently associated with cerebral palsy, a condition in which brain damage has resulted in loss or impairment of muscular control. Whatever process has so damaged brain tissue as to result in the palsy, whether it be birth injury, faulty development, or disease or accident, may also have damaged nerves controlling the eye muscles. Where this occurs there will be inefficient use of the eyes, and sometimes eventual loss of sight.



Possibly the most neglected visually handicapped child is the one who is mentally defective, though educable. Most classes for the visually handicapped exclude the mentally defective, while programs for the latter group seldom make use of materials and methods which help to relieve the disadvantages of the visual defect.

### *Extent of the Problem*

Estimating the number of visually defective children in Illinois is a difficult task. There has been no comprehensive enumeration, either in Illinois or elsewhere, of the exact group of our interest, i.e., all children under 21 with any eye abnormality. Such studies as have been made have many limitations. They cover different age groups, and contain risk of error in application to our group, since rates tend to vary for different ages. Many cover only children in school, reaching neither children not of school age, nor those of school age who are not attending school either because of their handicap or because of other reasons. Some use different definitions of visual defect from ours, and in some the method of determining the presence of visual defect is unreliable. However, by reviewing these studies, while recognizing their limitations, we can arrive at a reasonably useful estimate to apply to Illinois population figures.

**Studies outside Illinois.** Several nation-wide efforts to count the blind or estimate their numbers are widely quoted. These include the United States Census, the National Health Survey, and the estimates of Mr. Ralph Hurlin, Director of the Department of Statistics of the Russell Sage Foundation and a long-time member of the Committee on Statis-

tics of the Blind. However, the Bureau of the Census discontinued counting the blind after 1930 because of the admitted inaccuracy of their figures, which, depending on lay enumeration exclusively, missed many blind persons. The National Health Survey of 1935-36, which has offered many useful data on the health of the general population, defines blindness essentially as inability to distinguish light from dark, and hence its estimate of numbers of the blind is low. Mr. Hurlin's figure is high for acceptance without substantiation through additional studies, and it includes no age breakdown. The age breakdowns for the other studies offer wide variation in the percentage of the blind under the age of 20 years.

The White House Conference on Child Health and Protection in 1930, after reviewing various studies prior to that date, made an estimate as to the prevalence of eye defects among elementary school children.<sup>4</sup> According to this estimate probably 20 per cent of children in elementary schools have some eye defect. Of these the vast majority are completely correctible with medical treatment and glasses. Approximately two-tenths of 1 per cent of these children would, even after medical care and fitting of glasses, still be classified as partially seeing. Only five one-hundredths of 1 per cent would be classified as blind.

Two studies, one of preschool children<sup>5</sup> and the other of teen-age preparatory school boys<sup>6</sup> are of special importance because they were done by ophthalmologists and are therefore presumed to have picked

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<sup>4</sup> *White House Conference on Child Health and Protection*, Section III, *Special Education, the Handicapped and the Gifted*, pp. 126-127.

<sup>5</sup> *Vision of Pre-School Children*, Publication No. 66, National Society for the Prevention of Blindness, New York.

<sup>6</sup> Albert E. Sloane, M.D., and J. Roswell Gallagher, M.D., "A Summary of Findings at the Eye Examination of Preparatory School Boys," *American Journal of Ophthalmology*, XXVI (October, 1943), pp. 1076-83.

up every existing eye abnormality in each child. (An *ophthalmologist*, like an *oculist*, is a physician specially trained in the science which relates to the structure, function, and diseases of the eye. Both are to be distinguished from *optometrist*—who is not a physician and who deals primarily with eye conditions which can be corrected by glasses—and *optician*—who manufactures, but does not prescribe or fit glasses.) Both studies show substantially the same percentage of eye defect—20.9 per cent among pre-school children, and approximately 20 per cent among the preparatory school boys.

The extensive health examination of young persons in the National Youth Administration program in 1941<sup>7</sup> showed approximately 20 per cent needing examination for glasses. There were other eye disorders as well. This figure was reached by use of the Snellen chart during examination by a physician, a method which will not detect all types of eye difficulties, and so the rate seems high in comparison with the previous figures. However, the NYA youths were from low income families, and it is a well-substantiated fact that physical defect is more prevalent in the lower income groups, because of such factors as malnutrition and lack of funds for medical care.

No reports are available on studies of large groups of children to determine how many of them, after adequate ophthalmological care, still have vision so defective as to be classified as partially seeing. Winifred Hathaway, of the staff of the National Society for the Prevention of Blindness, has estimated on the basis of broad experience in work with partially seeing children, that 1 in 500 school chil-

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<sup>7</sup> *The Health Status of NYA Youth*, Federal Security Agency, Washington (1942).

dren is in need of sight-saving class work.<sup>8</sup> This estimate includes some children whose vision is close to normal but who have eye difficulties needing the protection of the special environment of the sight-saving classroom. While this figure needs substantiation through adequate follow-up of vision testing programs in schools, it is in agreement with the White House Conference estimate and is quite generally used to predict the number of partially seeing school children in a given community.

**Studies in Illinois.** The two available studies of numbers of visually handicapped children in Illinois cover school children only. In 1940 the State Superintendent of Public Instruction conducted a limited survey to gain an estimate of the number of children in Illinois who were handicapped to such an extent that they needed special education facilities.<sup>9</sup> The local school superintendents reporting estimated that 2 per cent of their total enrollment suffered from visual defects sufficiently severe to necessitate special education. On the basis of this figure it was estimated that 25,472 children in Illinois schools needed special education because of visual defect. This number is high in comparison with other estimates, and a rather detailed unpublished report of the survey indicates that there were wide variations in definition of defect on the part of those participating.

Between 1935 and 1942 an extensive vision screening project was carried on in Illinois schools by the WPA, under sponsorship of the Illinois Society for the Prevention of Blindness. The findings are especially significant because of the very large

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<sup>8</sup> Winifred Hathaway, *Education and Health of the partially Seeing Child*, p. 20.

<sup>9</sup> See *The Illinois Plan for Special Education of Exceptional Children—The Physically Handicapped*, Superintendent of Public Instruction, (Springfield, 1944, pp. 9-10).

number of tests done. The examiners were lay people, carefully instructed in use of the Snellen chart, which was the only examination procedure used although teachers were asked to report any classroom behavior which might be suggestive of eye defect. In 1,763,727 tests made between 1935 and 1942 in 78 counties of the state, covering city, rural, and some parochial schools and a wide grade range, evidence of defective vision was found in 198,265 cases, or 11.24 per cent of the total.<sup>10</sup>

Although in every case in which a child showed evidence of vision definitely below normal, his family was notified and examination by an ophthalmologist recommended, the recommendation was not always followed. Corrective medical attention was reported as secured in 88,927 cases of the more severe defects. Follow-up service was not available to secure reports from the doctor in every case where the child did receive eye care, and we do not, therefore, have any conclusive figures to show what percentage of children, after corrective medical attention, still had vision sufficiently defective to necessitate their education through special sight-saving classes.

In reviewing the findings of this survey in the Chicago area over a five-year period, it was noted that the percentage of correctible eye defects picked up had been reduced from 17.5 per cent to 10.8 per cent.<sup>11</sup> This is a significant demonstration of the fact that extensive case-finding and follow-up, continued over a period of years, will definitely cut down the incidence of eye defects.

These figures from the WPA study must be regarded as very conservative, as the Snellen chart

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<sup>10</sup> Unpublished summary data furnished by Mrs. Audrey Hayden Gradle, Executive Secretary, Illinois Society for the Prevention of Blindness.

<sup>11</sup> *Ibid.*



examination alone, though the recommended and useful tool for general vision screening in schools, will miss certain eye defects which the ophthalmologist can find. The significance of the figures is that they show a basic minimum of children with eye defects.

**Estimates for Illinois.** From these figures, how can we arrive at a working estimate of the number of visually handicapped children under 21 years of age in the State? There seems justification for applying the White House Conference estimates to Illinois population figures, since several of the other studies cited tend to support the White House Conference figures. In taking estimates which were originally made for an elementary school population and applying them to the total population under 21, in and out of school, we take a recognizable risk of error, but this is somewhat lessened by the fact that the limited studies on preschool and teen-age children tend to substantiate the same figures.

In 1940 Illinois had 2,513,297 residents under 21 years of age. Using the White House Conference estimates, 20 per cent of these, or slightly over 500,000, might be expected to have some degree of visual defect, which in the vast majority of cases would be fully correctible with medical care and/or glasses. Within this group two-tenths of 1 per cent of the total, or about 5000, would be expected to have a sufficiently severe visual defect, even with medical care and glasses, to be classified as partially seeing. A still smaller proportion, five one-hundredths of 1 per cent of the total, or about 1250, would be classified as blind.

We have then an estimated group of 500,000 children who are our concern because of some de-

gree of eye abnormality. Their individual needs will vary widely, from medical care to special education, to personal adjustment services, to vocational guidance and training. Among them about 5000 will need the services which can help overcome the handicap of partial sight, and about 1250 will need the services which help to alleviate the handicap of blindness.

### *An Ideal Program*

Every child has certain needs which must be met if he is to develop according to his best potentialities and become a happy, useful, and self-supporting adult. These needs include a family life in which the child is loved and accepted; a home and neighborhood which are physically and mentally healthy; medical care which will prevent or correct illnesses and physical defects; recreation; an education which will fit his individual abilities, interests, and needs; and opportunity through proper counseling, training, and job placement, to become self-supporting.

The child with a physical handicap has exactly the same needs, but if they are to be met he may require special services. An ideal program for any group of physically handicapped children will include prevention; case finding; medical care; education; training of personnel to give special services; vocational guidance, training, and individualized job placement; and social and psychological services. Throughout such a program, high quality and continuity of services, broad coverage, and constant individualization of the child are essential.

**Prevention.** In recent years we have learned a great deal about how to prevent blindness, but con-

stant vigilance is necessary to be sure that we are applying all we have learned. Perhaps the most important single preventive measure is control of communicable diseases. As we prevent or lessen the severity of such diseases as measles, scarlet fever, and meningitis, and particularly as we prevent or treat adequately syphilis and gonorrhea, we cut down the incidence of blindness, since all of these diseases may do damage to the eyes which results in loss of sight.

Adequate public health services, available in every community and staffed by specially trained doctors and nurses, are essential in the control of communicable disease. Certain legal measures in venereal disease control are of great importance to sight conservation. These include the requirements: (1) that silver nitrate drops be placed in the eyes of all newborn babies to prevent development of gonorrheal infection of the eye which might have been acquired during birth; (2) that before a marriage license is issued, each applicant must present evidence of freedom from venereal disease, both to locate and place under treatment unrecognized cases of infection, and to prevent transmission of infection to marital partner or unborn child; (3) that every pregnant woman be given a blood test for syphilis on her first visit to a physician, so that every syphilitic expectant mother may receive intensive treatment which will protect her own future health and prevent infection of her child.

Safety education and industrial hygiene are important in prevention of many of the accidents which may damage or destroy sight. Traffic control is of great importance, as an increasing number of persons have been blinded by automobile accidents in



recent years. Rigid control of fireworks, firearms, and explosives is important in cutting down on preventable injuries from these sources. Prompt and adequate medical care is essential in prevention of blindness, since good sight can frequently be conserved in spite of dangerous illness or injury if immediate expert medical services are available.

Prevention of blindness requires adequate community education, so that citizens are conscious of the importance of eye health, and how sight may be safeguarded. Health and safety education must be carried on extensively, both in the classroom and throughout community activities. Classroom teachers especially need emphasis on such education, since they are in a strategic position to guard the eye health of children.

**Case Finding.** Adequate case finding of visually handicapped children must include both comprehensive census methods which will detect children with obvious defects, and a program of health examination by a physician, with referral to an eye specialist as necessary, in order to detect the more obscure difficulties and to determine the extent of visual defect.

Probably the most promising census method is that of the child accounting system, which would make a yearly count of all children from birth to 21 years of age, enumerating all known handicapping conditions, and reporting to a central agency which would maintain a continuous state register and refer all children in need of service to the proper agency.

Such a system, while locating many handicapped children, would miss those whose defects were not easily recognizable by lay persons and who had

not yet come under medical care. This can easily happen with certain types of visual defects, particularly in preschool children. It is therefore necessary to supplement the child accounting plan by a school health program which will provide for physical examination of every child before entering school and at regular intervals thereafter. Such examination would be done by a physician, following vision screening tests done by properly instructed lay persons. Provision should be made for referring to an eye physician any child who appeared to have an eye abnormality. Under such a plan, a great deal of the necessary medical care would be secured in the usual way from physicians in private practice, but provision should be made for care through other means for children whose families could not pay for private care.

An ideal program for eye health in children includes yearly vision screening in the school. It is generally agreed that such screening with the Snellen chart can be done by the classroom teacher, properly instructed, with all children appearing to have defects, or questionable cases, referred to the school nurse for re-check and follow-up. The teacher must also understand and report unusual appearance or behavior which might suggest eye abnormality. These procedures will not pick up all eye defects, but they will catch the great majority of them, and speed the child's referral to an eye physician. In some states traveling or regional diagnostic clinics have been an additional important means of locating visually handicapped children.

The well-trained public health nurse is a key person in the case finding program, both because she is in a position to locate many of the children

who are in need of eye care, and because she is the strategic person to interpret to parents the importance of medical care for the child, and to follow up to see that the care is actually received. She is an essential guardian of the school child's health, and every school needs public health nursing service as a part of its total health program.

**Medical Care.** Eye care should be given by physicians with specialized training in treatment of eye abnormalities or disease. Certification by the American Board of Ophthalmology is evidence that a physician has met high standards of training and experience in treating disorders of the eye. Public medical care programs should specify that all eye care be given by specialists and that surgery and major treatment be done by physicians certified by the American Board of Ophthalmology.

Ophthalmological care is an essential for every visually handicapped person. Before any type of special service is begun there should be an ophthalmological examination to determine the exact nature of the eye defect, so that the service program can be adapted to the individual eye needs. In addition, any treatment measures which might prevent or retard loss of sight or restore sight to any degree should be carried out, and necessary appliances, such as glasses or artificial eyes, should be provided. The visually handicapped person should be under regular supervision by an ophthalmologist throughout his life. The ideal program will guarantee that every child receives ophthalmological care when he needs it, regardless of his geographical location in the state or the financial status of his family.

Private patient care is, of course, the backbone of such a program and reaches the greatest number

of children. Where families cannot pay for private care, ophthalmologists' services should be available through voluntary clinics or hospitals or public medical care programs. Standards for financial eligibility in the public programs should be sufficiently flexible to accept all children who are not cared for otherwise, and there should be sufficient correlation between private and public care so that no children are lost between them and go without needed attention. Public funds should be available as necessary to pay transportation and living costs where children must be taken outside their own communities for eye care. The experience of the Division of Services for Crippled Children of the University of Illinois in serving children with orthopedic, plastic, and speech difficulties, has demonstrated the values in having an agency able to coordinate all treatment efforts in behalf of a handicapped child, and maintain a continuous record of his individual situation.

There are several possible means of overcoming the handicap of geographical distance in securing specialized medical care. There is great need to encourage young specialists to establish practice outside the larger cities, but to date little progress has been made in this direction. Where there are good roads and transportation facilities, people can safely travel farther to receive medical care than in former days. Traveling clinics, such as the Illinois Trachoma Clinics, are one way of getting specialists' services to the more isolated areas; establishing outlying branches of special eye hospitals is another. The problem of making ophthalmological service available to the rural and semi-rural population is part of the whole problem of maldistribution of medical care and cannot be settled apart from the whole.

The availability of an eye specialist, geographically and financially, will not alone assure that a child gets to him for needed care. Increased public education is needed to help the general population understand the importance of eye care and the need of consulting an eye physician immediately if there is any sign of eye difficulty. This is a joint responsibility of the medical profession, schools, and public health and welfare agencies. In addition, all case finding programs, especially in the schools, should do an intensive follow-up job to be sure that the child in need of eye care actually gets to the eye physician.

**Education.** The visually handicapped child is more like than unlike the normal child and his educational needs are basically the same. It is true that, if his handicap is marked, he requires some special services in the school which are adapted to his limitations of sight, so that he has equal educational opportunities in fact as well as in theory. However, such a program of special education can be built up successfully only on the basis of a sound general educational system in the state and in the local school districts, embodying the best of modern knowledge as to educational method and materials and providing attention to the child's individual needs. It is, therefore, of concern to anyone interested in the welfare of handicapped children that the whole school system of the state be strong.

The preschool blind child needs, first of all, experiences as much like those of the sighted child as possible. He needs understanding and affection from a family which accepts his blindness realistically, help in developing independence and self-reliance, opportunity for vigorous physical activity



and play with other children, and sharing in activities such as shopping, parties, and travel.

In addition the preschool blind child needs certain special experiences and training because of his blindness. These include experiences in which sound and touch are substituted for sight, since he cannot learn through seeing. He must be helped to avoid or correct any so-called "blindisms," unpleasant mannerisms such as keeping the head down, waving fingers before the eyes, or rocking the body back and forth.

Meeting these needs is primarily a responsibility of the child's own family. Some families meet them intuitively, but there is danger that a family may not do so because of ignorance or an unhealthy attitude toward the blindness. Since unless these needs are met adequately the blind child may be seriously retarded in development, the family of every preschool blind child should have access to the services of a skilled professional counselor, who can help them understand the child and train him wisely. This service should be available on a state-wide basis, regardless of financial status or geographical location of the family, and should be closely related to medical, child welfare, and school programs, since the counselor will often find the child should be referred to one of these for additional care. If the child cannot receive adequate care in his own home, after sufficient trial has been made, boarding home care or, occasionally, placement in a children's institution will need to be arranged. In a few instances special nurseries for blind babies have been established, but the evidence to date does not indicate that this is either necessary or desirable in Illinois if counseling service is provided.

During his school years, the blind child continues to need substitution of sound and touch for sight in the learning process, and the broadest possible range of experiences in normal living. He must acquire the same body of knowledge and the same mental skills as the sighted child, though the methods by which he does this will be adapted to his individual needs and potentialities, and the school therefore needs to have adequate medical, psychological, and social information about him. In the elementary grades he should master Braille reading and writing, and the use of the typewriter, which will be of basic importance to him throughout his life. He should have a physical education program which will help him avoid or correct any problems in posture, gait, or muscular coordination which may be connected with his blindness, as well as give him sport skills, recreational experience, and good general health. The educational program, if it is to fulfill its objective of preparing the child for later life, must provide for his association with sighted children, and should give him sound vocational guidance according to his individual requirements, and in some instances actual vocational training. How far the child goes in school should depend—as it should with the seeing child—on his mental capacity, his interest, and his specific job goal. He should have the opportunity for as long a formal education as will be of concrete usefulness to him, whether this stops in high school or goes through college and professional school.

The child's ability to benefit by this type of education will be markedly affected by his own and his family's attitude toward his handicap. It is therefore essential that there be close cooperation be-



tween school and family, so that both accept and work toward the same goal. Where the child, because of unfortunate experiences in the home, has developed a poor attitude toward his blindness, he should receive direct help in solving this problem.

There are two types of school program for blind children, and both would be included in an ideal program at this time. Day school Braille classes, in which the child lives at home and attends a regular school but spends part of the day in a special room where he learns Braille, typing, etc. under a specially trained teacher, are the most modern method of educating the blind. They are, however, feasible only in metropolitan centers, since elsewhere there will not be enough blind children to fill such a class. The day school classes have the advantage of giving the child a normal experience of association with sighted children, while teaching him the essential techniques of learning as a blind person. All the accessory services to the regular classroom program as outlined above, can be provided through the day school set-up, given adequate planning and financing. This program will require constant cooperation between special and regular teachers, and careful interpretation of what the blind child can do, so that he is not excluded from any activities in which he might share.

It is essential that where the child, whether blind or partially seeing, is in a special day school class under the non-segregated plan, he not be segregated in extra-curricular activities any more than in the classroom. Groups such as Scouts and Camp-fire Girls should not be for handicapped children alone, and sports, parties and excursions should mix the visually handicapped with the normally sighted.

Such a plan has values not only for the handicapped child but also for the normal, who thereby learns to understand and accept as his fellows those who are physically different.

The residential school seems, to date, the most practical means of meeting the educational needs of the blind child who lives where day school classes are not available. Such a school admits children from the whole state and educates them without charge, just as other public schools do. Through a variety of special materials and techniques, the same as those used in the day school classes, the blind child is given the same education as sighted children receive. Like the day school classes, the residential school should require ophthalmological examination to determine if the child needs its services. In addition it should require a general physical examination before the child becomes a member of a new living group.

In order to assure the child continuing social and psychological services during his enrollment in the residential school, the staff should include a clinical psychologist and one or more social caseworkers. The psychologist will be able to evaluate individual abilities and achievement, and assist in the vocational guidance program. The case worker will help to maintain a close tie between the school and the home, and will assist the child at the school in adjusting to his visual handicap and to the school program.

The advantages of the residential school are that it assures special education to the blind child, no matter how isolated his home, and is able to concentrate full attention on the problems of education of the blind. The disadvantages are that the child is

away from his home and family living for long periods of time and is completely segregated from sighted children, an experience which gives him poor preparation for later living in a sighted world. Concern for these problems has led a number of experts in recent years to advocate that in instances where the child does not have access to day school Braille classes, he remain in the residential school only long enough to acquire the essential techniques and familiarity with special materials, and then return to classes with sighted children. Such a change may well be made between the grammar and high school grades. There is ample proof that blind children who have mastered Braille and related skills can get along satisfactorily in regular high school with the aid of readers and some provision of Braille and talking books. Careful interpretation to the local day school is necessary, as well as continued supervision of the blind child's program to insure that he does actually get the benefits of participation in the activities of sighted children.

Education for the blind student beyond the high school grades should be based on a realistic plan which takes into account his intelligence and aptitudes, his school record, and the specific job opportunities which such education will open up for him. In college or professional school he will need reader and sometimes guide service, and these extra expenses should be recognized by provision of special scholarship aid. This is appropriately given on a statewide basis from public funds. A requirement for such scholarship aid should be that there is reasonable assurance the specific plan for higher education will prepare the individual for work at which he can be fully self-supporting.

The educational needs of partially seeing children differ somewhat from those of the blind. They must be educated as seeing people, but they require certain modifications of the regular school program. The physical set-up of the classroom, as well as the educational materials and procedures, must be such as to promote the most efficient use of the child's defective sight. Ophthalmological care which defines the exact nature of the eye defect and indicates what is safe use of the eyes for the individual child, psychological examination to determine individual capacities and interests, close cooperation between school and home, and vocational guidance and sometimes training are important essentials.

Partially seeing children are not in need of special educational procedures before the regular school age. In the formal school program their needs are best met through the so-called "sight-saving" class. (This is something of a misnomer, since the class functions primarily to offset the educational handicap of partial sight, and usually can do little in actual sight conservation. However, the term is generally used for the sake of convenience.) Such classes should be established as a part of the regular school system wherever eight or more students can be brought together in one building, with the special materials, classroom set-up, and trained teacher. The organization plan is cooperative, that is, in the special room the students do work which requires close use of the eyes, and in the regular classroom they do the rest of their work with the other students of their grade. Standards for such classes have been authoritatively outlined by the National Society for the Prevention of Blindness,<sup>12</sup>

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<sup>12</sup> Hathaway, *op. cit.*

and should be followed closely. Like the blind child, the partially seeing child needs a close contact between home and school, provided by visiting teachers (school social workers), so that the benefits of the special program can be maintained for him through cooperative effort.

The partially seeing child in the isolated community presents certain additional problems. In some instances, he is close enough to a school district maintaining a special class so that he can attend. This should be encouraged wherever possible. There will in any state be some children for whom such a plan cannot be worked out. In some states a sight-saving class has been maintained in the state school for the blind to meet the needs of this group. However, such a plan has the disadvantage not only of taking the child out of his own home and of segregating him from normally sighted youngsters, but of placing him in a setting which centers around the educational needs of the blind, which are very different. All other methods of working out a program for the partially sighted child should be exhausted before such a class is organized. It is sometimes possible to arrange for boarding home care, preferably on a five-day basis, in a community maintaining a sight-saving class. An alert classroom teacher, with the benefit of professional consultation, may bring about some modification of the regular program so that the child, though remaining in his regular classroom in his home community, may be at a minimum disadvantage educationally. The latter plan would need to be a direct responsibility of the state department of public instruction, which could give counseling service and supervision to the local school and maintain a lending library of special materials, so



that the local school would not have undue expense for one child. Improvement in school lighting and desks to meet the needs of the partially sighted child would also be of value to any other children in the school.

Decision as to the school placement of each visually handicapped child ought to be made on the basis of individual ophthalmological, social, psychological, and educational study, together with a knowledge of community resources for special education. The Division of Education of Exceptional Children in the office of the State Superintendent of Public Instruction should be able to arrange for such individual study, and make recommendations for individual placement accordingly. Under such a plan, school placement would be made on the basis of meeting individual needs most satisfactorily, rather than because of various more casual reasons.

The educational goal for the child with both mental retardation and visual defect is the same as that for other mentally retarded children—self-care, ability to get along with other people, and ability to do some useful work, occasionally even to the point of self-support. This requires careful examination of all educable mentally handicapped children to determine where visual handicap exists, medical correction where indicated, and special education based on individual physical and mental capacities. Wherever any of the special techniques or materials of training of the visually handicapped can help the doubly handicapped child in achieving this goal, they should be provided. This will mean the addition of specially trained teachers and special materials to the school program of institutions for the mentally retarded, and to the ungraded room organization in large



school systems. The psychological examination which determines the child's mental status must also take into account the eye defect, in order to plan his training wisely. The child's family should be helped to face realistically the fact of the double defect, the limitations it imposes, and what possibilities there are for the child.

A state educational program for the visually handicapped must be so planned as to take care of the deaf-blind when these are located. Their education is a highly technical matter, requiring much time and skilled attention. In general, at the present time, the education of the deaf-blind is carried on in schools for the blind, and the greatest advances have been made in the few schools in the country which maintain special departments for the deaf-blind. A state program should provide either for specially trained personnel and liberal use of special consultants in speech, hearing, and psychology, in the school for the blind, or it should permit payment from public funds for the child's education outside the state in one of the recognized centers for education of the deaf-blind. There is much to recommend the latter procedure, since there are few educable deaf-blind children in any one state, and institutions which gather them together from a considerable territory have a better opportunity to develop the most effective techniques for their instruction.

Teachers of either the blind or the partially seeing require specialized training, in addition to those courses on problems of the exceptional child which should be a part of every teacher's basic training. Preparation for teaching the two groups has some elements in common, but the instructional materials and techniques learned are entirely different. The

American Foundation for the Blind and the National Society for the Prevention of Blindness have cooperated in sponsoring training courses for teachers of the blind and partially seeing respectively and have defined the necessary course content. A state with a number of teacher training institutions should offer courses in special education within its borders, and the State Superintendent of Public Instruction should establish standards and recognize special education training by a special certificate.

**Employment.** An ideal vocational program for the visually handicapped is essentially the same as that for any other group, handicapped or not. All young people need guidance and training which will prepare them for work to which they are suited and at which they can earn a decent living. Since serious visual defect, particularly blindness, narrows the choice of jobs, it is particularly important that the visually defective child be guided toward one of the things he can do.

The elements in a satisfactory vocational program include determining individual abilities and interests, vocational counseling based on these findings, vocational training, and job placement. The first two of these should be available during school years and as a part of the school program; where schools are not yet staffed to give this type of service, there should be cooperation from state agencies in the vocational field. Aptitude testing for the blind or partially seeing must be done by people familiar with the implications of these handicaps, using test material adapted to the use of the visually handicapped.

There has not been complete agreement in the past as to whether vocational training of the visually

handicapped should be done in the school or following completion of a regular academic program. The same principles apply here as to the non-handicapped group—vocational training should be available when the individual requires it. For some students this will be during high school years, for others after completion of high school or even college. Each student should have an individualized program, suited to his own abilities and interests and to real job opportunities. It is no more wise, for instance, to train every blind high school student in weaving or basketry or piano-tuning, than to assume that every one can successfully pursue a classical college course with later professional training. The trend in thinking, however, seems to be toward the regular school concentrating on academic, prevocational training, leaving the job of vocational training to the trade or technical school.

Job placement of the visually handicapped, particularly of the blind, requires professional skills and a philosophy of emphasis on the things which the handicapped person can do, rather than on those which he cannot do. Recent experience has shown a very large number of jobs which can be handled successfully by the blind, including some at which the trained manual dexterity and concentrated attention of the blind are special advantages. Any blind student now being educated should be assured the fullest possible range of choice in job preparation and treatment. The attainable goal of vocational training of the blind should be that every young blind adult, otherwise without handicaps, be self-supporting in work suited to his skills, intelligence, and personality.

There is still much discussion as to whether vocational services for the blind should be given by a general vocational rehabilitation agency or by a special agency for the blind. Successful work has been done under both plans. However, there is no basic reason why good services cannot be given the blind through the general agency, and strengthening its program benefits all the physically handicapped. It is important that the vocational program, wherever handled, be closely integrated with medical and educational programs, so that there is continuity of service to the individual.

The extent of vocational handicap of the partially seeing depends on the nature and severity of the eye defect. Sound vocational guidance is more frequently needed than special training, so that the child begins early to look toward work in which his defective sight will not be a handicap. In the past, emphasis on vocational training for the blind has led to some neglect of the partially seeing child. When, but only when, careful study reveals he is handicapped in his choice of jobs, he should receive as many of the special services outlined as he may need.

**Other Services.** Public assistance to the blind may occasionally be helpful in providing maintenance for a person under 21 during a period in which other services are preparing him for future self-support. In general, however, public assistance should not be necessary for the young blind because of blindness alone. If the total program of services in a state is adequate, every blind child who is not otherwise handicapped should grow up to self-maintaining adulthood.

Home teaching is another service primarily for the adult blind which may in occasional instances be

needed by younger people. A newly blind adolescent who had finished high school might find it difficult to adjust to the residential school program to learn Braille and could utilize to better advantage the services of a home teacher, who, in addition to teaching Braille and typing, could help him in his adjustment to daily living. Home teaching is needed in every state and should be available as the occasion demands to the younger blind who are past school age.

**Financing the Program.** Substantial public financing is necessary to assure adequate services to visually handicapped children. Public funds should be available to pay for any of the services previously outlined which are not otherwise provided for, and State and Federal funds should supplement local funds as needed. It is important that eligibility requirements for service through public programs be sufficiently flexible so that no child is excluded from needed care on technicalities when he is not assured care elsewhere.

By and large, most of the services outlined will be given by public agencies and exact costs will have to be determined as experience is gained. Public expenditures in preventive, medical, educational, and vocational services, in so far as they achieve their goal of producing self-maintaining and self-reliant adults and prevent dependency and unnecessary handicap, are actually more than repaid.

### *Resources Now Existing in Illinois*

Resources may be classified under the same headings as the items in an ideal program of services. A number of them, however, are of value in more than one aspect of the total program. Medical re-



sources, for instance, contribute both to prevention and to treatment of visual defect.

**Prevention.** For a number of years the Illinois Society for the Prevention of Blindness has offered leadership throughout the state in activities which might prevent or lessen the occurrence of visual defect. Maintained by private contributions and memberships, the Society bears a large share of responsibility for the development of the various public programs for prevention of blindness in Illinois, as well as for extensive case finding of the visually handicapped, establishment of sight-saving classes, and requiring examination by an ophthalmologist for recipients of public assistance to the blind. Its service in carrying on experimental work on a demonstration basis, preliminary to establishment of public programs, has been of great importance, as has its work toward sound legislation, and it cooperates closely with public agencies working with the visually handicapped.

Illinois has a number of excellent laws which contribute to prevention of blindness. These include a requirement for instilling an approved prophylactic in the eyes of newborn infants to prevent gonorrheal ophthalmia;<sup>13</sup> premarital examination for venereal disease;<sup>14</sup> and prenatal blood test for syphilis for every pregnant woman on her first visit to a physician.<sup>15</sup> In addition there are legislative provisions restricting the manufacture and sale of fireworks, and controlling their storage and handling,<sup>16</sup> and regulating the possession of firearms.<sup>17</sup>

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<sup>13</sup> *Ill. Rev. Stat. 1945*, Chap. 91, Sec. 106-113.

<sup>14</sup> *Ibid.*, Chap. 89, Sec. 6a.

<sup>15</sup> *Ibid.*, Chap. 91, Sec. 113a-113c.

<sup>16</sup> *Ibid.*, Chap. 38, Sec. 276.1-276.31.

<sup>17</sup> *Ibid.*, Chap. 38, Sec. 152-158b.



The 1943 laws permitting establishment of county health departments<sup>18</sup> and providing for physical examinations for school children<sup>19</sup> will, when implemented, strengthen general health protection of children and contribute to case finding of the visually handicapped and to prevention and treatment of eye defect.

**Education.** Illinois makes its principal provision for the education of blind children through the State School for the Blind, established as a state institution in 1849. It is open without charge to any blind child in the state and offers academic education through high school, as well as some vocational courses. The School has been particularly noteworthy for its contribution to standardization of the Braille alphabet, and for the development of Braille music notation. There were 212 students in attendance during the 1943-44 school year, 184 classified as Braille students, and 28 in sight-saving classes.<sup>20</sup>

Braille day school classes maintained by the Chicago public schools since 1900 were the first of their kind in the country. In February 1945 there were 60 students enrolled in elementary and high school Braille classes.<sup>21</sup> Children living outside Chicago may attend these classes upon payment of tuition and, when necessary, transportation by their local school district. The classes are on the cooperative plan, with the child spending time in the special classroom only for study, examinations, and lesson preparation.

Special services required by children with defective vision increase the costs of their education,

<sup>18</sup> *Ibid.*, Chap. 34, Sec. 148-149.

<sup>19</sup> *Ibid.*, Chap. 122, Sec. 27-8.

<sup>20</sup> Communication from Mr. Robert W. Woolston, Superintendent.

<sup>21</sup> Figures secured from Miss Katherine Barrett, Co-ordinator for Handicapped Children, Chicago Public Schools.

and these excess costs are recognized as a responsibility of the State.

The School Code provides that local school districts may claim reimbursement from the State up to a maximum of \$300 per child per year for the excess costs of special educational services which they furnish for children whose physical handicaps make such services necessary.<sup>22</sup>

In 1943-44, sight-saving classes were maintained in 36 communities in the state, including Chicago, with a total of 848 students for whom State reimbursement for excess costs of special education was paid on the basis of their membership in such classes.<sup>23</sup>

Higher education for the blind in Illinois is furthered by the State Board of Education for the Blind, Deaf, and Dumb. This Board may furnish financial assistance up to a maximum of \$500 per annum to blind and/or deaf and dumb students regularly enrolled and pursuing a course of study in an institution of higher learning or a vocational or professional school.<sup>24</sup> In 1939-40, 44 blind students received such aid.<sup>25</sup>

Under existing law the State Superintendent of Public Instruction is responsible for establishing requirements for training of teachers of the blind and partially seeing. At present a committee of consultants to the State Superintendent is working on formulation of such standards, but they have not yet been published. Two colleges in Illinois have recently set up curricula for training teachers of the visually

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<sup>22</sup> *Ill. Rev. Stat. 1945*, Chap. 122, Sec. 12-20, 12-27.

<sup>23</sup> *Excess Cost of Educating Handicapped Children Paid by the State of Illinois for the School Year Ended June 30, 1944*, Mimeographed report of State Department of Public Welfare.

<sup>24</sup> *Ill. Rev. Stat. 1945*, Chap. 23, Sec. 38a—38b.

<sup>25</sup> *Higher Education of the Blind and Deaf of Illinois 1941*, State Superintendent of Public Instruction, p. 13.

handicapped. As part of its total plan for training in special education, Illinois State Normal University is developing a course of study for teachers of the partially seeing, and MacMurray College has arranged a curriculum for workers with the blind, including teachers, involving joint use of the facilities of the college and of the Illinois State School for the Blind.

**Treatment.** Chicago, as one of the medical centers of the country, has a large number of highly skilled ophthalmologists, and excellent eye clinics and hospital facilities for the care of eye disorders. In the state as a whole, according to 1944 figures subject to correction for military service, there were 160 physicians certified as specialists by the American Board of Ophthalmology. Of these, 128 were located in Cook County, and the remaining 32 were scattered rather evenly throughout the state, with not more than 4 in any one county.<sup>26</sup> There are, in addition, an unknown number of physicians restricting their practice to treatment of eye, or ear, nose, and throat disorders, who for one reason or another have not been certified by the American Board.

In addition to the private practitioners who handle the major volume of eye care, a number of specialized public resources exist in the state. The oldest of these is the Illinois Eye and Ear Infirmary, in Chicago, under joint administration of the State Department of Public Welfare and the University of Illinois, as a resource for free treatment of eye, ear, nose, and throat conditions of indigent persons from any part of the state. Children are accepted as patients.

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<sup>26</sup> *Diplomates of the American Board of Ophthalmology*, Up to, and Including January 1st, 1941, American Board of Ophthalmology, Portland, Maine, plus supplements to January 1, 1945.

The Trachoma Clinics, in southern Illinois, initiated by the Illinois Society for the Prevention of Blindness and now maintained by the State with the assistance of the Society, have been of great importance in preventing loss of sight from this serious eye disease. Intensive case finding and treatment, using the very effective "sulfa" drugs, have had marked success in cutting down the amount of trachoma existing in an area where it was formerly a scourge. In the course of the medical care program, the trachoma clinics have also been a means of locating many visually handicapped children and referring them to special schools and other needed services.

The Glaucoma Clinic at the Illinois Eye and Ear Infirmary was initiated by the Illinois Society for the Prevention of Blindness in 1939 and is now carried largely by State funds. It serves both adults and children and provides both medical care and intensive follow-up for patients suffering from glaucoma, a condition in which increased pressure within the eyeball will, unless relieved or checked by medicine or surgery, cause severe damage to sight. Follow-up is handled by a medical social worker.

The Division of Services for Crippled Children of the University of Illinois is in process of extending its program to include complete care for children with eye conditions which may produce permanent serious handicaps.

**Vocational.** Under existing Federal-State legislation, blind or partially seeing persons in Illinois are among those who may receive the full range of services of the Division of Rehabilitation of the State Board for Vocational Education. These services in-

clude general and specialized medical examination, physical restoration and appliances, vocational counseling, vocational training beyond high school, individualized job placement, and follow-up to insure continued successful employment. The physical restoration program is at this writing in process of organization.

Blind persons are also eligible under the law for vocational training and employment in the Illinois Industrial Home.<sup>27</sup> In practice, however, this institution is primarily a custodial home for the adult and aged blind, and the workshop attached is under the direction of the Division of Visitation for the Adult Blind. The Division, in addition to its workshop activity, provides home teaching service for the adult blind throughout the state and sponsors the vending stand program which offers employment to adult blind persons in public buildings in the state. Most of the persons receiving the services of this Division are over the age of 21; under some circumstances they may be of importance to younger persons, particularly through the home teachers.

**Other Services.** Another public service for the blind is the Blind Assistance Program, giving financial aid to needy blind persons. This joint Federal-State program, established under the provisions of Federal Social Security Act and State Statutes, is administered by the Illinois Public Aid Commission. Formerly such assistance in Illinois could be given only to persons over 18 years of age, but the minimum age limit was removed by the 1945 General Assembly.

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<sup>27</sup> Ill. Rev. Stat. 1945. Chap. 23, Sec. 105, 110, 112.



The Institute for Juvenile Research, a Division of the State Department of Public Welfare, offers psychological, psychiatric, and casework services to children in any part of the state. The services of the Institute are given outside Chicago through a system of clinics maintained in several down-state centers. Any child in need of the attention which the Institute can give is eligible for service if he can get to one of the centers.

We see, therefore, that Illinois already has a number of resources for service to children with visual defect. These include particularly strong preventive legislation, skilled medical care (though this is concentrated largely in one small corner of the state), legal provision and financial assistance for special education, special schools and classes, specialized psychological services, and a vigorous private agency with a statewide program in prevention of blindness and service to the partially seeing. Even with these, however, we cannot yet say that an adequate job is being done for every blind or partially seeing child in the state, and it is important that we examine carefully the existing programs to determine exactly where and how they fall short of complete service.

### *Unmet Needs*

**Case Finding.** Outstanding among the unmet needs of visually handicapped children in Illinois is a case finding program which will locate and register all children with eye abnormalities. At present the lack of an adequate program of this sort means that we do not have exact figures as to the size of the problem to use as a basis for planning. Until there is overall case finding there will always be some chil-



dren going without care until they develop serious visual difficulty or associated educational and social problems which might have been avoided.

**Prevention.** It is obvious that visual defects should be prevented wherever possible. Although excellent preventive work has been done in Illinois, there is still need to make public health services uniformly available. While some areas in the state are at present well organized and staffed for public health work, this is by no means uniformly the case, and many schools even yet have no school nursing service.

**Medical Care.** Illinois has outstanding resources for eye care in its specialized medical practitioners, eye clinics, and hospitals. However, these facilities are not so distributed as to insure that children in all parts of the state have access to specialized eye care when needed. To a considerable extent these special facilities are concentrated in the Chicago metropolitan area, with many gaps downstate. While geographical distance is not an insuperable obstacle to obtaining specialized medical care, the expense and effort necessary to overcome it are discouraging, and in emergency situations the results may be tragic. The problem is financial as well as geographical, and many families who are otherwise self-maintaining cannot pay for specialized medical care as private patients. Thus, even where there is an adequate supply of ophthalmologists, financial problems prevent some children from receiving needed eye care.

**Education.** Nothing has been done in Illinois to meet the special needs of the educable mentally handicapped child who is also partially seeing or blind. He is generally excluded from special schools

and classes for the visually handicapped, and none of the classes or schools for the mentally retarded has the special materials and physical set-up which the visual defect requires.

At the present Illinois has no organized program for deaf-blind children. While the number of such children in the state is probably very small, it is reasonable to expect that there are some, but to date there is no centrally available information as to exactly who and where they are. Neither state residential school has a special deaf-blind department, suitably staffed and equipped, and there is no existing provision to educate them outside the state at public expense at one of the nationally recognized centers.

Every child with visual defect needs to be assured such special education as will minimize his handicap and give him the best opportunity to become a self-maintaining and useful citizen. We cannot yet say that this right is assured every child in Illinois. Resources for special education are thus far best developed in the most highly populated centers and leave much to be desired in rural areas. The isolated child with visual defect is particularly at a disadvantage, and much needs to be done to insure his having the special educational materials and procedures which are called for. At present even those children who are receiving some type of special education because of visual defect are often placed in a given school set-up without sufficient individual study to establish that placement as the one which best meets his total needs.

In the state's residential school program, both blind and partially seeing children are accepted. Provision is made for partially seeing students who have

no sight-saving class available in or near their home community. While they receive the advantages of a standard sight-saving educational program, they miss completely the daily association with seeing students which is a part of the day school sight-saving class. In a school for the blind they are in a falsely superior position—"in the realm of the blind, the one-eyed is king"—which cannot prepare them adequately for the realities of living in a sighted world.

Although psychological study is available in the state residential school for any student who shows signs of difficulty, it is not done routinely as a basis for academic and vocational planning for every child. There is not sufficient social study of the child and his family before his admission to give adequate understanding of him as an individual, and the school does not have a staff to provide casework services to the child and his family during his enrollment. The vocational training program, while teaching a variety of crafts, emphasizes primarily the traditional trades followed by the blind and does not as yet reflect the wide range of work possibilities developed during wartime experience. A large number of the students go into employment in special workshops for the blind, whereas the most recent thinking is that this should be necessary only for those blind persons who have some other handicap, mental, physical, or personality, which disqualifies them for work with sighted people. There is no policy for routine referral of students leaving school to the State Division of Vocational Rehabilitation for further vocational training or placement.

No plan has as yet been developed to return blind students to regular day school after they have mastered their Braille techniques. They thus get all

their academic education through high school in a segregated situation which does not offer daily association and competition with the sighted. The fact that the school has no organic relationship to the rest of the public school system of the state makes transfer of blind students to day school more difficult. The law includes among the duties of the Superintendent of Public Instruction visiting "such of the charitable institutions of the state as are educational in their character, to examine their facilities for instruction, and to prescribe forms for such reports as he may desire from their superintendents,"<sup>28</sup> but this provision has not been actively observed. The very fact that the school is classified as a "charitable institution" rather than as a school is contrary to modern thinking in education of the handicapped, and to the trend in legislation throughout the country.

Although the law requires that teachers of the blind and partially seeing in classes receiving State aid for excess costs shall have special training as outlined by the State Superintendent of Public Instruction, detailed requirements have not yet been published. There is as yet no certificate for training in special education, and few school districts give recognition, in higher salary levels, to the additional training the special teacher has had. Accordingly there is little incentive to prepare for special class teaching.

**Vocational.** To date the school programs in Illinois offer little in the way of vocational counseling to the visually handicapped child, and what counseling there is usually does not start as early as needed, that is by junior high school years. The blind or partially seeing child usually has only limited access to vocational courses in the schools for sighted chil-

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<sup>28</sup> Ill. Rev. Stat. 1945, Chap. 122, Sec. 2-13.

dren. There is little referral between schools and vocational agencies to assure that the visually handicapped child will have continuous service adapted to his need, and vocational training programs are not well coordinated.

**Other Services.** We now have very little in the way of specialized psychological services for visually handicapped children in the state. Even though the facilities of the Institute for Juvenile Research are open to children from any part of the state, and the Institute participates in the programs of child guidance clinics in several communities, there are still very real difficulties in the way of children in some of the more remote rural areas receiving psychological study when needed.

Just as psychological services are not yet adequate, so social services are not available to all children when and where needed. Since the effectiveness of other efforts may be lost if the child with visual defect has unrelieved home or personality problems, an intimate tie-up between social and other services is needed at all stages of the child's care. In general this means that generalized social services are needed in every county, since State programs with small specialized staffs cannot maintain sufficiently close contact with the child to provide all recommended social treatment and follow-up.

There are now a number of agencies serving visually handicapped children in Illinois. These have been established at different times and for different purposes, and their programs vary widely. Coordination of all these efforts is highly necessary if the objectives of an adequate program for visually handicapped children are to be attained. The need



for such coordination is being recognized at this time, but plans remain to be worked out in terms of clear-cut policy making.

Given recognition of these unmet needs of our children who lack normal sight, how can we move toward the sort of program that recognizes, individualizes, and serves adequately every one of these children, wherever he is?

### *Recommendations*

**Case Finding.** Case finding of children with visual defects can be made effective through two recommended developments. The first of these is a child accounting system which will keep track of every child under 21 years of age, record any known or observed defect, and maintain a central state register with permanent records, so that the child is not lost between school districts if he moves about the state. Child accounting, since it includes the functions of a school census, might logically be the duty of the State Superintendent of Public Instruction.

While child accounting would locate many pre-school children with severe visual difficulties, implementation of the legal provision for a school health program is an urgent necessity for more adequate case finding among children of school age.

**Prevention.** Organization of county health departments as permitted under 1943 legislation will improve public health services in the state and should proceed as rapidly as possible, thereby serving the cause of prevention of blindness as well as many other aspects of community health. Every school should have public health nursing service as a basic essential of the school health program.



**Treatment.** The Division of Services for Crippled Children, with its already well-established system of itinerant clinics and follow-up care, might well add to its present program of eye surgery complete service for children with any type of eye difficulty whose needs are not met otherwise.

**Preschool Program.** A state-wide counseling service for the families of preschool blind children is urgently needed and might appropriately be provided through one of the units of the State Department of Public Welfare. An excellent beginning could be made by one worker, with medical social work or child welfare background and a thorough understanding of eye difficulties.

**Double Handicaps.** Provision should be made for meeting the double need of children who are both mentally retarded, though educable, and visually handicapped. Where enough children with the double handicap can come together in one place, a special class which meets both needs should be established. Otherwise classes for the mentally retarded should borrow such materials and procedures from standard education of the partially seeing or blind as will be helpful to the individual child. This principle applies to the institutions for the mentally handicapped as well as to the special education programs of the day schools and to the state residential school for the blind.

Since the number of deaf-blind children in the state is probably very small, provision for payment for their education in one of the special centers outside Illinois is recommended as more economical than the establishment of such a center within the state.

**Education.** Each visually handicapped child, either at the time he enters school, or when development of the visual defect makes special education necessary, should receive sufficient ophthalmological, social, and psychological study so that a sound recommendation for school placement can be made, and so that the school which he subsequently attends will have an adequate understanding of his individual needs and abilities on which to plan its service to him.

Since the Illinois School for the Blind is so outstanding a resource for education of the blind child in Illinois, the adequacy of its program is of great concern to the state. The logical means of insuring that the school offers the most modern and complete educational program possible is to arrange that the State Superintendent of Public Instruction have supervision of the educational aspects of the school. The appropriateness of welfare supervision of the residential aspects of the school is not questioned, but if the teaching program is under educational supervision, it can be integrated more closely with the rest of the public school system and can be planned toward the blind child's return to a regular school at as early a grade as possible.

The addition of adequate psychological and social services in the State School are recommended as being of the utmost importance.

The school sight-saving program needs to be enlarged to provide adequate services for the isolated partially seeing child who cannot attend a sight-saving class in or near his home community. Experimentation with special help to the child in his own school should be begun, through the office of the State Superintendent of Public Instruction, with ar-

rangement where necessary for foster home placement in a community which has a sight-saving class.

As soon as specific standards for teacher training are established by the State Superintendent of Public Instruction, only teachers meeting those standards should be employed in any special education program claiming reimbursement from the State. The training program for teachers of classes for the blind or partially seeing already planned or in process of organization should be strengthened in every possible way.

**Vocational.** Vocational services to the visually handicapped should be strengthened, first through getting vocational guidance and counseling into all school programs, beginning at least with the junior high school grades; second, through improving vocational training in the schools, both in quality and in range of subject matter; and third, through building up the state vocational rehabilitation program. The first will require more training of all teachers in vocational guidance, and also provision of specially trained counselors who can give aptitude tests and are familiar with job opportunities and the particular skills and training they require. The second means a realistic appraisal of job opportunities and the types of job training which are an appropriate part of the general school program, and provision for such training in the school, through adequate instructors and equipment. The third means enlarging the staff of the State Division of Rehabilitation to include enough professionally trained workers, chosen on a merit basis, to be able to give highly individualized guidance and placement service, and also implementing the physical restoration program already permitted under the law.

**Psychological Service.** Improved psychological service for the visually handicapped child is recommended, both through extension of the services of the Institute for Juvenile Research and through the addition of clinical psychologists to local school systems of sufficient size to be able to utilize full-time psychological services.

**Social Service.** Adequate social services should accompany every program serving the visually handicapped child, whether medical, educational, or vocational. The establishment of a medical social service department serving all patients at the Illinois Eye and Ear Infirmary would benefit children receiving eye care there. As the eye program of the Division of Services for Crippled Children gets under way, it is assumed that it also will include medical social service.

The Illinois School for the Blind and the special classes for the visually handicapped in Chicago should have sufficient visiting teacher staff to serve all children as needed, as should every other special class for the visually handicapped in the state which is in a school district large enough to make the employment of such specialized personnel feasible. Where this cannot be done, closer working relationships with local family or child welfare services should be established. The extension of child welfare services in the state and the establishment of county welfare departments are necessary to insure more adequate care to the child in rural areas.

**Coordination.** A close and continuing coordination of all programs of service to the blind is recommended, so that the individual may receive continuing service according to his need. This can be

achieved through the establishment of definite policies of referral, cooperation, and division of responsibility among the several existing agencies. Leadership in this coordination might well be taken by the State Department of Public Welfare, which already includes several of the existing services and has some relationship with the others.

Adequate service to the visually handicapped, as to any group of handicapped children, will require close cooperation and exchange of information between health, welfare, education, and employment agencies in every community and at every level of government. Together these agencies can accomplish much more than by working separately, and their coordinated effort can assure the child with visual defect his rightful opportunity to become a contributing citizen in his community. Such coordination will depend to a considerable extent on educating all persons who work with visually handicapped children—whether they are doctors, nurses, teachers, social workers, or psychologists—to an understanding of the total needs of the blind or partially seeing child.



## *Suggestions For Further Reading*

*A Basic Plan for Health Education and the School Health Program*—Issued jointly by Vernon L. Nickell, Superintendent, Office of Public Instruction; Roland R. Cross, M.D., Director, Department of Public Health; Frank G. Thompson, Director, Department of Registration and Education—July, 1944, State of Illinois.

A booklet prepared for the use of local communities in planning their own programs of school health and health education.

*Directory of Activities for the Blind in the United States and Canada, Including Prevention of Blindness Organizations and Sight-saving Classes*—Compiled by Helga Lende—5th edition, June, 1943—American Foundation for the Blind, Inc., New York.

Covers Illinois, and national agencies which also serve Illinois.

*The Education of the Blind Child*—1943—American Foundation for the Blind, Inc., New York.

A leaflet which reviews helpfully both the care of the preschool blind child and formal education of the blind in special schools and classes.

*Facts about the Education of Blind Children*—1939 (?)—New York Institute for the Education of the Blind, New York.

Illustrated booklet issued by one of the oldest and most progressive residential schools for the blind.

Frampton, Merle E. (Ed.)—*Education of the Blind*—1940—World Book Co., New York.

A thorough-going discussion of education of the blind, including many of the most recent developments in educational method and content.

Frampton, Merle, Ph.D., and Rowell, Hugh, M.D.,—*Education of the Handicapped*, Vol. 1—*History*, Vol. 2—*Problems*—1938—World Book Co., New York.



One of the most useful general texts on education of the handicapped. Includes chapters on the blind and partially seeing.

Hathaway, Winifred—*Education and Health of the Partially Seeing Child*—1943—published for National Society for the Prevention of Blindness by Columbia University Press, New York.

A comprehensive discussion of all aspects of education and health of the partially seeing child. Based on long and wide experience, it is the standard work in the field.

Hearon, Eleanor L.—“Emotional Factors in Education of the Visually Handicapped”—reprinted from *The Sight-Saving Class Exchange*, No. 67, February, 1939.

Of particular interest to social workers. Shows the need for an all-around approach to the child's problem.

Heck, Arch O.—*The Education of Exceptional Children*—1940—McGraw-Hill Book Co., Inc., New York.

A standard text on education of the handicapped, including chapters on the blind and partially seeing.

Illinois Society for the Prevention of Blindness—*Annual Reports*—Mrs. Audrey Hayden Gradle, Executive Secretary.

Vividly written and readable reports which show the progress of prevention of blindness in Illinois under the vigorous leadership of the Illinois Society.

Martens, Elise H.—*Residential Schools for Handicapped Children*—Bulletin 1939, No. 9—U. S. Office of Education, Federal Security Agency, Washington, D. C.

Based on country-wide familiarity with residential schools for the handicapped, this study describes standards as well as existing practices in schools for the blind.

May, Charles H., M.D.—*Manual of the Diseases of the Eye*—18th edition, 1943—William Wood and Co., Baltimore.

A widely used textbook on diseases of the eye. While written primarily for physicians and medical students, some of the text and many of the illustrations are of interest to lay people.

*Outlook for the Blind and the Teachers' Forum*—monthly—American Foundation for the Blind, Inc., New York.

This publication covers all subjects of interest concerning the blind.

*Sight Conservation through Fuller Understanding of the Patient, A Symposium*—supplement to *The Sight-Saving Review*, Vol. 9, No. 4, December, 1939.

Illustrates ways in which the social worker can be of service to the visually handicapped.

*The Sight-Saving Review*—quarterly—National Society for the Prevention of Blindness, Inc., New York.

A publication which covers all phases of sight conservation and service to the partially seeing.

Speer, Edith L. (Director, The Lighthouse Nursery School)—*A Manual for Parents of Pre-School Blind Children*—New York Association for the Blind, New York, 1944.

A very helpful booklet giving practical suggestions for care of the preschool blind child. Probably the best currently available on this subject.

*Teachers' Problems with Exceptional Children, I—Blind and Partially Seeing Children*—Beatrice McLeod—1933—U. S. Office of Education, Federal Security Agency, Washington, D. C.

A booklet which answers many of the teacher's questions about the blind or partially seeing child.

*What of the Blind*—edited by Helga Lende—Vol. 1, 1938; Vol. 2, 1941—American Foundation for the Blind, Inc., New York.

These two volumes are made up of articles by authorities on a wide range of subjects concerning blindness and the blind. Valuable reference material.

*White House Conference on Child Health and Protection, Section III, Special Education, the Handicapped and the Gifted—1931—Century Co., New York.*

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*Section IV, The Handicapped: Prevention, Maintenance, Protection—1933—Century Co., New York.*

Interesting and detailed material on handicapped children, including sections on the blind and partially seeing. Some of the material is now dated and no longer entirely accurate.

In addition to these specific references, useful material on a variety of subjects may be obtained from two national agencies. For material on the blind, address the American Foundation for the Blind, Inc., 15 West 16th St., New York 11, N.Y. For material on sight conservation and service to the partially seeing, address the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

## *Acknowledgment*

All publications of the Commission for Handicapped Children are a result of the combined efforts of all members of its staff. To them recognition is hereby made.

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